Department of Health and Human Services
Health Care Financing Administration
Operational Policy Letter #110
OPL99.110

Date: December 22, 1999

Subject: Standard Reporting Requirements for Medicare Managed Care Organizations in 2000: Health Plan Employer Data and Information Set (HEDIS7 2000) Measures that Include the Medicare Health Outcomes Survey (HOS) and the Medicare Consumer Assessment of Health Plans Study (CAHPS7 2.0H), and Disenrollment Rates.

Effective Date: December 22, 1999

Important Changes from 1999

This OPL provides information regarding the 2000 Medicare HEDIS submission and provides clarification for Medicare contracting organizations under applicable law, regulations and contract requirements governing Medicare+Choice (M+C) organizations, the Section 1876 cost contracting organizations, and demonstration projects. Throughout this document, the general term, managed care organization (MCO), will be used to refer to all contracting organizations, unless otherwise specified. During the past year, HCFA reviewed the requirements in place for HEDIS 1999 with the goal of reducing any unnecessary burden and expense of collecting quality and performance data while at the same time ensuring compliance with statutory requirements. Therefore, HEDIS 2000 requirements contain some significant changes. Please review the entire document thoroughly. Highlights of changes are listed below:

- HCFA will not require MCOs to report HEDIS 2000 data if the MCO's first Medicare enrollment occurred on February 1, 1999 or later. In addition, MCOs with Medicare enrollment below 1,000 as of July 1, 1999 will not be required to submit HEDIS 2000. (See I.C.6).

- Measures required to be submitted:
  Note that the HEDIS 2000 measure set includes a new measure in the Effectiveness of Care Domain "Controlling High Blood Pressure," and that "Comprehensive Diabetes Care" is now a required measure that incorporates the "Eye Exams for People with Diabetes" measure. The Comprehensive Diabetes Care measure was optional for HEDIS 1999. Also note that HCFA is not requiring the submission of all the measures that are classified by NCQA as applicable to the Medicare population. For HEDIS 2000, HCFA has reduced the number of measures that will be required for submission. Review Attachment I for the specific list of required measures.

- First year measures:

  NCQA has instituted a new approach to the introduction of new measures called "first year measures." First year measures are part of the reporting set but NCQA recommends that the results should not be publicly reported for individual MCO to MCO comparison. This will permit further fine-tuning of the technical specifications and collection processes. These measures must be collected, submitted and undergo the audit process. HCFA will adopt the same policy regarding first year measures. Therefore, HEDIS 2000 rates for "Controlling High Blood Pressure" will not be published in *Medicare Compare.*

- Similar to HEDIS 1999, MCOs will be required to undergo an NCQA Compliance Audit, conducted by an NCQA-licensed audit firm. Details of the NCQA audit methodology are described in *HEDIS 2000 Volume 5: HEDIS Compliance Audit: Standards, Policies, Procedures*. This year, MCOs will be required to undergo a Full Audit. Last year HCFA required a "partial audit," that is we specified a list of measures that the audit firm reviewed. However, over the past year we have reviewed this policy and have determined that the full audit provides the most benefit and flexibility for both the MCO and HCFA in a cost-effective manner. Extrapolation from the core measure set to the entire set of measures submitted, coupled with the audit opinion rendered on the entire set, enables HCFA to be assured that the data are valid. In addition, following the receipt by the MCO of the Final Audit Report from the NCQA-licensed audit firm, a copy of the complete final report must be submitted to HCFA. (See II.B).

- Mergers and Acquisitions: HCFA has determined that the entity surviving a merger or acquisition shall report both summary and patient-level HEDIS data only for the enrollment of the surviving company. Previously, HCFA required MCOs to report the Effectiveness of Care measures for the members of the non-surviving contract.

- Appeals and grievances data: HCFA plans to collect appeals and grievances data from MCOs in the near future. MCOs should refer to OPL 99.081 for more information.

- Disenrollment rates: In 2000, HCFA will begin reporting disenrollment rates, as required under the Balanced Budget Act of 1997. HCFA also will begin

nationwide administration of the Medicare CAHPS7 Disenrollment Survey. HCFA plans to report the results of the survey with disenrollment rates in 2001. At this time, HCFA is finalizing the details for both the rates and the survey. HCFA will keep MCOs apprised of rate and survey development through standard communication channels including industry groups and the HCFA Regional Offices. **HCFA, not MCOs, will calculate disenrollment rates, and HCFA will pay for the Medicare CAHPS7 Disenrollment Survey.**

- Measure rotation: NCQA implemented a measure rotation strategy for the commercial and Medicaid product lines starting with HEDIS 2000. The rotation strategy does not include Medicare so reporting of prior year rates will not be permitted.

Background

Effective January 1, 1997, HCFA began requiring MCOs to report on performance measures from the HEDIS7 reporting set relevant to the Medicare managed care population, and to participate both in CAHPS7 and the Health Outcomes Survey (HOS). This OPL explains reporting requirements for HEDIS 2000, HOS, and CAHPS and addresses specific HCFA requirements regarding how MCOs must implement HEDIS 2000, HOS, and CAHPS. CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

These requirements are consistent with HCFA's statutory and regulatory authority and contract terms with MCOs with regard to obtaining the information necessary for proper oversight of the program. It is critical to HCFA's mission that it collect and disseminate information that will help beneficiaries choose among MCOs, contribute to better health care through identification of quality improvement opportunities, and assist HCFA in carrying out its responsibilities.

HCFA makes summary, plan-level performance measures available to the public through media that are beneficiary oriented, such as the *Medicare Compare* Internet site (www.medicare.gov) and the *Medicare & You* handbook. A subset of HEDIS and CAHPS data is also available in printed form through a toll free line (1-800-MEDICARE). Disenrollment rates will be available in printed form through the same toll free line after May 2000. The complete HEDIS summary data files received will be available through HCFA's Internet website as a Public Use File (www.hcfa.gov). The HEDIS, CAHPS, and Disenrollment Survey patient-level files will be available at cost to requesters authorized to receive such information. Requesters, for confidentiality reasons, must sign a Data Use Agreement with HCFA and must meet HCFA's data policies and procedures that include, but are not limited to, submitting a research protocol and study purpose. For information about Data Use Agreements, contact the Division of Data Liaison and Distribution, Enterprise Database Group, within HCFA's Office of Information Services.

Please note that where there are differences between this policy letter and HEDIS 2000 Volume 2, this OPL takes precedence for reporting data. The final HEDIS 2000 Volume 2: Technical Specifications is available from NCQA. Please call NCQA Publications at 1-800-839-6487 to obtain a copy. Download periodic corrections to Volume 2 from the NCQA web site: http://www.ncqa.org/pages/policy/hedis/corrections2k.htm

PROGRAM REQUIREMENTS

2000 Contract Year	**Sampling Frame/Period**	**Dates for Participation Eligibility**	**Minimum Sample Size**	**Market Area Reporting**	**Financial Responsibility**	**Demonstrat**
HEDIS 2000 and HEDIS 2000 Audit	Services delivered in 1999 (and earlier for some measures)	First Medicare Enrollment on 1/1/99 or earlier Minimum Medicare Enrollment of 1,000 as of 7/1/99	Measure specific (MCOs must report all HCFA-required Medicare measures according to instructions)	Yes	MCO pays for external HEDIS Audit	Yes, as spec in section I.C below
Health Outcomes Survey	Members continuously enrolled 6 months prior to administration of survey	Medicare contract in place no later than 1/1/99	1000 (If less than 1000 enrollees, all members must be surveyed.)	Yes	MCO pays for NCQA-certified vendor to administer survey	Yes (See section I.C.10)
CAHPS	Members continuously enrolled 6 months prior to administration of survey	Medicare contract in place no later than 7/1/99	600 (If less than 600 enrollees, all members will be surveyed.)	Yes	HCFA pays for survey administration	Yes (See section I.C.10)

IMPLEMENTING HEDIS 2000 MEASURES AND MEDICARE CAHPS

I. Specifics Applicable to CAHPS and HEDIS

A. Effects of the Balanced Budget Act of 1997

The Balanced Budget Act of 1997 established Part C of Medicare, known as the M+C program which replaced the section 1876 program of risk and cost contracting starting with contracts effective January 1, 1999. The reporting requirements contained in this OPL apply to organizations that hold an M+C contract, a section 1876 cost contract, or a demonstration contract, in accordance with applicable law, regulations, and contract requirements. Please see section C below for exceptions to this requirement, such as organizations that have terminated their M+C contract or section 1876 contract with HCFA for 2000.

B. Requirements for MCOs

1. Reporting Requirements

a. HEDIS 2000: A MCO must report HEDIS 2000 measures for their Medicare managed care contract(s), as detailed in the *HEDIS 2000 Volume 2: Technical Specifications* if:

- the contract was in effect on 1/1/99 or earlier;
- the contract had initial enrollment on 1/1/99 or earlier;
- contract had an enrollment of 1,000 or more on 7/1/99;
- the contract has not been terminated on or before 1/1/00.

The Medicare relevant measures in HEDIS 2000 that M+C MCOs must report are listed in Attachment I, and the Medicare relevant measures in HEDIS 2000 that continuing cost contractors must report are listed in Attachment I.A. Please note that some measures that were submitted for HEDIS 1999 are not being required for HEDIS 2000 even though HEDIS 2000 Volume 2 lists them as Medicare measures.

b. Health Outcomes Survey: All MCOs and PACE (Program of All-Inclusive Care for the Elderly) plans that had a Medicare contract in effect on or before January 1, 1999 must comply with the HOS requirements during 2000. See the chart at C.10. for specific requirements for demonstration projects.

c. Medicare CAHPS: All MCOs that had a Medicare contract in effect on or before July 1, 1999, must comply with the CAHPS survey requirements during 2000. Medicare CAHPS does not apply to MCOs that received a contract effective after July 1, 1999. However, such MCOs may be required to undertake an enrollee satisfaction survey during 2000 to comply with the HCFA regulations on physician incentive plans (Vol. 61, Federal Register, 13430, March 27, 1996). Plans may wish to use Medicare CAHPS for this purpose.

2. Minimum Size Requirements: This year there is a minimum size requirement for MCOs to report HEDIS 2000 measures; MCO enrollment must be 1,000 or more on 7/1/99. In reviewing previous HEDIS submissions, HCFA noted that this is the enrollment level at which most MCOs could submit valid data on the Effectiveness of Care measures. There is no minimum size requirement to participate in the HOS and Medicare CAHPS surveys. When an MCO has fewer beneficiaries enrolled than the CAHPS sample size of 600 or the HOS sample size of 1,000, at the time the sample is drawn, the entire membership must be surveyed.

An MCO must report all the HCFA-required Medicare HEDIS measures, even if the MCO has small numbers for the denominator of a measure. For specific instructions on how to handle small numbers, review the Specific Guidelines in the *HEDIS 2000 Volume 2, Technical Specifications*. For information regarding the audit designation for these measures review *HEDIS 2000 Volume 5: HEDIS Compliance Audit: Standards, Policies, Procedures*.

3. Sampling and Reporting Unit: The "contract-market" is the reporting unit for HEDIS, CAHPS, and HOS and implies either reporting by contract or by a market area within a contract. MCOs must report once for each contract "H" number unless HCFA divides the contract service area into "market areas." When the contract service area is subdivided by HCFA, the resulting market areas cover more than one major community or city and each market area has at least 5,000 Medicare enrollees. In these situations, MCOs will report two or more sets of data for a given contract. This approach will provide more meaningful information to beneficiaries, MCOs, and HCFA. There are no exceptions to reporting by market area where applicable.

HCFA will assess all contract service areas to determine whether the MCO must report by market area. HCFA will notify MCOs in writing whether they must report by market area and will identify the geography of each market area. MCOs that are not notified of market area reporting will report by contract. HCFA supplies NCQA with the list of MCOs that will be required to report HEDIS 2000 and for whom NCQA will furnish the Data Submission Tool8 (DST).

Note that HCFA has not changed the reporting unit methodology for HEDIS 2000, CAHPS, and HOS that was instituted with the first year of HEDIS reporting. We recognize that the Balanced Budget Act and ensuing regulations and policy have significantly impacted the service area configurations of MCOs and a number of MCOs are consolidating multiple contracts within a state for the 2000 contract year. In addition, the BBA requires HCFA to report comparative quality and satisfaction information for managed care and fee-for-service in a manner not previously required. Extensive analysis and review of an appropriate geographic unit for collecting and reporting quality and satisfaction data is occurring now at HCFA. No change will be made to the reporting unit prior to HEDIS 2001.

C. MCOs with Special Circumstances

1. MCOs with Multiple Contracts: **A MCO cannot combine small contracts or designated market areas into a larger reporting unit.** An MCO with multiple Medicare contracts must report HEDIS 2000, CAHPS, and HOS surveys for each risk and cost contract held in 1999. HCFA will notify plans as soon as possible whether they must report by market area.

2. MCOs Carrying Cost or HCPP Members: HEDIS performance measures will be calculated using only the Medicare enrollment in the M+C contract or the section 1876 contract in effect at year end 1999. Therefore, the following beneficiaries should not be included in HEDIS calculations.

(1) any residual cost-based enrollees of a M+C contract
(2) any residual HCPP enrollees of a section 1876 cost contract
(3) any enrollees of a section 1876 cost contract, operated by an MCO with an active M+C contract, that was an HCPP in the prior contract year and is not open for enrollment.

For HEDIS measures with a continuous enrollment requirement and for enrollees who converted from one type of contract to another (with the same organization), enrollment time under the prior contract will not be counted.

3. MCOs with New Members "Aging-in" from Their Commercial Product: MCOs with members "aging into" their Medicare product from their commercial product must consider those members eligible for performance measure calculations assuming that they meet any continuous enrollment requirements. That is, plan members that switch from a MCO's commercial product to the MCO's Medicare product are considered continuously enrolled. Please read the General Guidelines of *HEDIS 2000 Volume 2: Technical Specifications* for a discussion of "age-ins" and continuous enrollment requirements.

4. MCOs with Changes in Service Areas: MCOs that received approval for a service area expansion during the 1999 contract year and those that will be reducing their service area effective January 1, 2000 must include information regarding those beneficiaries in the expanding or reducing areas based on the continuous enrollment requirement and use of service provisions of the particular measure being reported.

5. HMOs with Home and Host Plans: The home plan must report the data related to services received by its members when out of the plan's service area. As part of the Visitor Program/Affiliate Option (portability), the host plan is treated as another health care provider under the home plan's contract with HCFA. The home plan is responsible for assuring that the host plan fulfills the home plan's obligations. Plan members that alternate between an MCO's visitor plan and the home plan are considered continuously enrolled in the plan.

6. New Contractors and Contractors below the minimum enrollment threshold: MCOs with initial enrollment on February 1, 1999 or later will not report HEDIS 2000

performance measures for calendar year (CY)1999. In addition, MCOs with enrollment below 1,000 on July 1, 1999 will not be required to submit HEDIS 2000. Therefore, MCOs with Medicare enrollment below 1,000 on July 1, 1999 will not receive a data submission tool (DST). However, these plans must have systems in place to collect performance measurement information so that they can provide reliable and valid HEDIS data in 2001.

7. Non-renewing/Terminating MCOs: Entities that meet the HEDIS reporting requirements stated above but who have terminated contracts effective January 1, 2000 will not be required to submit HEDIS data in 2000 for CY 1999 or participate in the HOS survey.

8. MCOs with Continuing Section 1876 Cost Contracts: For cost contracts, HCFA has modified the HEDIS measures to be reported. Cost contractors will not report the Use of Services inpatient measures. The measures to be reported are listed on Attachment I.A. HCFA does not require cost contractors to report inpatient (e.g., hospitals, SNFs) measures because MCOs with cost-based contracts are not always responsible for coverage of the inpatient stays of their members. Cost members can choose to obtain care outside of the plan without authorization from the MCO. Thus, HCFA and the public would not know to what degree the data for these measures are complete.

Cost contracts will provide patient-level data for all the HEDIS Effectiveness of Care and the Use of Services measures for which they submit summary level data. (See Attachment I.A.)

9. Mergers and Acquisitions: HCFA has determined that the entity surviving a merger or acquisition shall report both summary and patient-level HEDIS data only for the enrollment of the surviving company. Previously, HCFA required MCOs to report the Effectiveness of Care data for the members of the non-surviving contract; this reporting by the surviving entity applied if the non-surviving contract was in effect for any part of the measurement year. We have determined that the difficulties of securing valid data for that population outweigh the utility of receiving it and have deleted that requirement for HEDIS 2000.

We recognize that beneficiaries and affiliated providers may be associated with the surviving entity's contract. However, HCFA believes that HEDIS measures based on the combined 1999 membership and providers of both contracts could be misleading since the management, systems, and quality improvement interventions related to the non-surviving contract are no longer in place. Reported results based on combined contracts may not reflect the quality of care or medical management available under the surviving contract. The surviving contract(s) must comply with all aspects of this OPL for all members it had in 1999.

10. Demonstration Projects: HCFA also requires demonstration projects to meet the HEDIS, CAHPS or HOS reporting requirements, in accordance with applicable law,

regulations, and contract requirements. All types of demonstration projects will be expected to comply with all the HEDIS reporting and audit requirements in this OPL. Specific waivers contained in the demonstration contracts may have been negotiated with HCFA. For example, Evercare Demonstration Plans will NOT be required to participate in the Medicare Health Outcomes Survey in 2000. They are deferred for one year pending the refinement of a health outcomes data collection tool and implementation protocol. It is expected that Evercare will be required to participate in the refined survey in 2001. For information on the requirements for specific demonstrations, contact the HCFA project officer.

Demonstration	HEDIS 2000	HEDIS Audit	CAHPS	HOS
Social HMOs	Yes	Yes	Yes	Yes
Medicare Choices	Yes	Yes	Yes	Yes
Minnesota Senior Health Options	Yes	Yes	No	No
Wisconsin Partnership Program	Yes	Yes	No	No
Evercare	Yes	Yes	No	No
PACE	No	No	No	Yes
DOD Subvention	Yes	Yes	No	Yes

D. Implications for Failure to Comply

HCFA expects full compliance with the requirements of this OPL. MCOs must meet the time lines, provide the required data, and give assurances that the data are accurate and audited. In addition, many of the HEDIS requirements described in this OPL will be reviewed as part of HCFA's routine monitoring process as described in the 1999 Monitoring Guide which will be implemented beginning January 2000.

E. Use of Data

Data reported to HCFA under this requirement will be used in a variety of ways. The primary audience for the HEDIS, CAHPS, HOS, and Disenrollment summary data is the

Medicare beneficiary. These data will provide comparative information on contracts to beneficiaries to assist them in choosing among contracts. In addition, HCFA expects MCOs to use the data for internal quality improvement. The data should help MCOs identify some of the areas where their quality improvement efforts need to be targeted and may be used as the baseline data for Quality Assessment and Performance Improvement (QAPI) projects. Further, the data will provide HCFA with information useful for monitoring the quality of, and access to, care provided by MCOs. HCFA may target areas that warrant further review based on the data.

II. HEDIS 2000 Requirements

A. Summary and Patient-Level Data

HCFA is committed to assuring the validity of the summary data collected, before it is released to the public, and to make the data available in a timely manner for beneficiary information. **MCOs must submit HEDIS 2000 summary measures after completing the NCQA HEDIS Compliance Audit™ required by Medicare by June 30, 2000. MCOs must submit HEDIS patient-level data by June 30, 2000.** HCFA is requiring the submission of patient-level data on the same date as summary data to ensure that the patient-level data matches the summary data.

Please note that auditors will review patient-level data for the numerator and denominator of audited measures when checking for algorithmic compliance during the HEDIS audit. (See *HEDIS 2000 Volume 5: HEDIS Compliance Audit: Standards, Policies, Procedures* for more information on the audit process.)

1. Summary Data

a) *Required Measures*: MCOs that held M+C contracts in 1999 and meet the criteria in section C (1) of this OPL must report summary data for all required HEDIS 2000 measures identified in Attachment I, except for the Health Outcomes Survey measure (see discussion below at III). M+C MCOs that held section 1876 cost contracts and continuing open cost contracts must report summary data for all HEDIS 2000 measures identified in Attachment IA. **Please note that where there are differences between this policy letter and HEDIS 2000 Volume 2, this OPL takes precedence for reporting data.**

The HEDIS measures Flu Shots for Older Adults and Advising Smokers to Quit are collected through the CAHPS survey instrument.

MCOs must attempt to produce every Medicare required measure, and report a numerator and denominator even if the numbers are small, *i.e.* the denominator is less than 30.

b) *Data Submission*: The summary data for all HEDIS 2000 measures must be received by NCQA, HCFA=s contractor for the collection of data, by June 30, 2000. Specifications for calculating the summary measures are available in the *HEDIS 2000*

Volume 2: Technical Specifications, which is available from NCQA. Please call NCQA Publications at 1-800-839-6487 to obtain a copy.

NCQA will send MCOs the HEDIS 2000 Data Submission Tool8 (DST) in March 2000. MCOs must submit HEDIS results for the 1999 measurement year using this tool and should make sure that they have sufficient computing capability to run the DST. The tool is the same Microsoft Excel7-based application used in 1999, modified to reflect changes in the HEDIS 2000 specifications. NCQA will provide more information regarding the tool and the submission process to MCOs.

As in previous years, MCOs will not be allowed to change their data after submission to NCQA. The upgraded DST will allow MCOs to print a hard copy of the DST and to review all rates with their auditor prior to submission. The data submission to NCQA must include: a completed DST, a signed *Attestation of Accuracy and Completeness,* and a final audit opinion as described on page 77 of HEDIS 2000 Volume 5.

2. Patient-Level Data

Analysis of data with patient-level identifiers for the numerator and denominator of each measure allows HCFA to match HEDIS data to other patient-level data for special projects of national interest and research, such as an assessment of whether certain groups (*e.g.* ethnic, racial, gender, geographic) are receiving fewer or more services than others. These analyses will not be used for public plan-to-plan comparisons.

(a) *Required Measures*: MCOs must provide patient-level data identifying the contribution of each beneficiary to the denominator and numerator of every required summary measure on beneficiaries and each beneficiary's months of enrollment. Attachment II lists the clinical Effectiveness of Care process measures (excluding the Health Outcomes Survey measure) and the Use of Services measures for which patient identifiers and member month contributions must be provided. Beneficiaries shall be identified by their individual health insurance claim (HIC) number. The HIC number is the number assigned by HCFA to the beneficiary when he/she signs up for Medicare. MCOs use this number for enrollment accretions/deletions. The specifications for reporting patient-level data will be provided to MCOs by NCQA with the record layout information and detailed examples.

(b) *Data Submission*: NCQA expects to continue collecting patient-level data as a flat text file and will provide MCOs with the record layout in spring of 2000. **Plans must retain data used for reporting for three years.**

All patient-level data are protected from public dissemination in accordance with the Privacy Act of 1974, as amended. There have been questions and concerns expressed about the provision of patient-level data, particularly with regard to behavioral health measures. Plans are accountable for providing patient-level data, unless prohibited by state law. In such cases, plans must provide HCFA with appropriate documentation of the legal prohibition for HCFA's consideration.

B. HEDIS Audit: Certification of Data Accuracy

Because of the critical importance of ensuring accurate data, HCFA continues to require an external audit of the HEDIS measures before public reporting. **MCOs are responsible for submitting audited data.** In addition, the plan=s chief executive officer or president will be required to provide written attestation to the validity of the plan-generated data. The attestation form will be sent with the data submission tool to NCQA.

1. Requirement for an NCQA Full Audit

Last year HCFA required a "partial audit," that is we specified a list of measures that the audit firm reviewed. However, over the past year we have reviewed this policy and have determined that the full audit provides the most benefit and flexibility for both the MCO and HCFA. In a full audit, the audit firm selects a minimum of 14 measures across domains in the measure set, plus survey validation, that takes into consideration the MCO's operations and all payers. The findings can then be extrapolated to all measures reported by the MCO.

Our decision took into account the fact that the cost of a partial audit versus a full audit is not materially less since much of the audit involves reviewing the MCO's overall information systems infrastructure. In addition we have learned that a significant number of Medicare-contracting MCOs seek NCQA accreditation for their Medicare product line. NCQA accreditation scoring now includes data based on selected HEDIS measures. These measures used for accreditation must be audited whether or not HCFA required them to be audited. Furthermore, NCQA supports conducting full audits and only audited data will be used by NCQA in its information products. Many MCOs have determined from a cost-effectiveness standpoint that it makes sense to undergo a full audit. A full audit coupled with a purchaser's partial audit requirements may increase the cost to the MCO; therefore, HCFA did not want to add an extra burden to these plans. Finally, extrapolation across all measures would provide HCFA greater ability to display more measures to consumers since we are committed to using only audited data for consumer choice.

HCFA will present some number of audited measures on its *Medicare Compare* Internet site and in the *Medicare & You* handbook.

2. Health Plan Initiated Audit

HCFA requires each MCO to contract with an NCQA licensed organization for a NCQA HEDIS Compliance Audit and should do so in a way that will coordinate the audit process for all sources. The licensed audit firms are listed on NCQA=s web site at www.ncqa.org. HCFA will require that the licensed organizations use the NCQA *HEDIS 2000 Volume 5: HEDIS Compliance Audit: Standards, Policies, Procedures*. The Full Audit is described within this reference document. The health plan must ensure that the site visit audit team is led by a NCQA certified HEDIS Compliance Auditor and that the auditor is present during the site visit.

3. Final Audit Reports, Use and Release

Following the receipt by the MCO of the Final Audit Report from the NCQA-licensed audit firm, a copy of the complete final report as described in HEDIS 2000 Volume 5, beginning on page 77, must be submitted to HCFA at the following address:

HEDIS Audit Reports
c/o Musgrave, HCFA, OCSQ
S3-02-01
7500 Security Boulevard
Baltimore, MD 21244-1850

The copy of the Final Audit Report is due by July 30, 2000. NOTE: this is a new requirement. HCFA may use the assessment of the MCO's administrative and information systems capabilities that are contained in the audit report and may use the data to conduct post-submission validation.

HCFA will use the Final Audit Reports to support contract monitoring and quality improvement activities. Final Audit Reports are subject to the Freedom of Information Act (FOIA). HCFA will follow the FOIA regarding any release of such report and will make a determination about the release of information in each audit report on a case by case basis. Information that both the MCO and HCFA deem proprietary will not be released, unless otherwise required by applicable law.

III. The Medicare Health Outcomes Survey (HOS) Requirements

The Short Form (SF) 36 supplemented with additional case-mix adjustment variables will be used to solicit self-reported information from a sample of Medicare beneficiaries for the HEDIS 2000 functional status measure, Medicare Health Outcomes Survey (HOS). This measure is the first Aoutcomes@ measure for the Medicare population. Because it measures outcomes rather than the process of care, it is primarily intended for population-based comparison purposes, by contract- market. The HOS measure is **not** a substitute for assessment tools that MCOs are currently using for clinical quality improvement. In 2000 cohort 3 baseline will be drawn. As in prior years 1,000 beneficiaries per contract- market will be surveyed with a targeted response rate of at least 60 percent. If the contract-market has fewer than 1,000 eligible members, all will be surveyed.

Additionally, in 2000 the cohort one baseline respondents (originally surveyed in 1998) will be resurveyed. The results of this remeasurement will be used to calculate a change score for the physical health and emotional well being of each respondent. Depending on the amount of change the respondent will be categorized as having improved, declined, or as having undergone no change in health status over the two year period. Percentages of respondents whose health status improved, declined, and remained the same by plan will be released publicly in late 2000.

All M+C MCOs and continuing cost contracts that held section 1876 risk and cost contracts in 1999, as well as Social HMOs (SHMOs), PACE, and Medicare Choices demonstrations, with Medicare contracts in effect on or before January 1, 1999 must comply with this survey requirement during 2000.

MCOs, **at their expense,** are expected to contract with any of the NCQA certified vendors for administration of the survey **to both the new baseline cohort (cohort 3) and the remeasurement of cohort one (if the MCO participated in the 1998 HOS).**

You may begin contracting with vendors on approximately December 1, 1999. Contracts are expected to be in place by February 24, 2000 to ensure survey implementation by mid-March, 2000. Further details will be provided by NCQA, HCFA=s contractor, regarding organizing the survey.

To expedite the survey process, MCOs may be asked to provide telephone numbers or verify telephone numbers for the respondents unable to be identified using other means. MCOs must ensure the integrity of the data files they provide to the vendors by checking for, among other things, shifted data fields or out of range values. MCOs will be financially liable for the cost of any re-work (including but not limited to readministration of the survey) and subsequent delay by the vendor resulting from corrupt data files transmitted to the vendor by the MCO.

Since the Health Outcomes Survey measure looks at health status over a two-year period, results from the cohort 3 survey will not be publicly released in 2000. The follow up survey in 2002 will assess the same beneficiaries= health status compared to two years prior. Beneficiaries will be categorized into those who are better, the same, or worse over the two year period. Each contract- market score (the percent of beneficiaries who are better, the same or worse), will be reported in late 2000 for the 1998 cohort one follow up and in late 2002 for the 2000 cohort 3 survey. See Attachment III for additional information.

IV. Medicare CAHPS Requirements

A. Update on Round 2 of the 1998 Medicare CAHPS

All section 1876 risk and cost MCOs whose Medicare contracts were in effect on or before January 1, 1997 were required to participate in this administration of the Medicare CAHPS survey. For the second round, the Medicare Managed Care CAHPS survey was administered for all eligible Medicare contract-markets by a single independent contractor. The response rate was 81 percent.

HCFA selected the sample for each contract-market. Each sample included a random sample of 600 members who had been continuously enrolled in the contract for six months and were not institutionalized. For MCOs with fewer than 600 eligible members, all eligible members were surveyed.

Selected results from this survey were released to the public to facilitate plan-to-plan comparisons. Only data gathered through HCFA=s administration were publicly released. These data are being disseminated to the public via *Medicare Compare* (www.medicare.gov), 1-800-MEDICARE, as well as with the *Medicare & You 2000* mailout.

In August 1999, HCFA provided the MCOs participating in the HCFA administration of the CAHPS survey with detailed reports for their own internal quality improvement efforts, consistent with the Privacy Act (Title 5, USC, section 552a).

B. Information Regarding 1999 CAHPS

In the Fall of 1999, HCFA began to administer the third Medicare Managed Care CAHPS survey. M+C MCOs and continuing cost contracts with contracts in effect on or before July 1, 1998 were included. MCOs that terminated their contracts as of January 1, 2000 are included in this administration; however, these MCOs do not have to provide telephone numbers for the telephone follow-up of nonrespondents. Beneficiaries were eligible for the survey if they had been continuously enrolled for 6 months and were not institutionalized. The survey administration mode for the third round is identical to that of round 2: two mailings with telephone follow-up of non-respondents. To conduct the telephone follow-up of non-respondents in September 1999, we requested telephone numbers from MCOs for the CAHPS sample embedded within a larger list of beneficiaries enrolled in the MCO. **HCFA is paying for the administration of the survey.**

Selected results from this survey will be released to the public to facilitate plan-to-plan comparisons. Only data gathered through HCFA=s administration will be publicly released. These data will be disseminated to the public via *Medicare Compare* (www.medicare.gov), 1-800-MEDICARE, as well as with the *Medicare & You 2001* mailout.

HCFA will provide the MCOs participating in the HCFA administration of the CAHPS survey with detailed reports for their own internal quality improvement efforts, consistent with the Privacy Act (Title 5, USC, section 552a).

C. Information Regarding 2000 CAHPS

In the Fall of 2000, HCFA plans to administer the fourth Medicare Managed Care CAHPS survey. M+C MCOs and continuing cost contracts with contracts in effect on or before July 1, 1999 will be included. **HCFA is planning on paying for the administration of the survey.**

Contacts:

1. **HEDIS 2000 and HEDIS Audit:** MCOs should address all questions or requests for clarifications about the HEDIS 2000 Technical Specifications to NCQA's technical information line (202) 955-5697 or E-mail hedis@ncqa.org.

Questions about Medicare HEDIS not resolved through NCQA can be directed to Richard Malsbary at (410) 786-1132 in HCFA's Center for Health Plans and Providers. When contacting HCFA, MCOs should be prepared to tell HCFA both the advice that they received from NCQA and the individual at NCQA with whom they spoke.

Questions about the HEDIS audit can be addressed by Dorothea Musgrave at (410) 786-1099 in HCFA's Office of Clinical Standards and Quality.

2. **HOS:** For technical questions regarding the Medicare Health Outcomes Survey, please contact Chris Haffer in HCFA's Office of Clinical Standards and Quality at (410) 786-8764.

Questions relating to the vendors or survey protocol should be addressed to Jessica Corrigan at NCQA at (202) 955-3570.

3. **CAHPS:** For technical questions regarding Medicare CAHPS, please contact Liz Goldstein at (410) 786-6665 or Lori Teichman at (410) 786-6684 of HCFA=s Center for Beneficiary Services.

4. **Disenrollment:** For technical questions regarding the Medicare CAHPS Disenrollment Survey or Disenrollment Rates, please contact Chris Smith-Ritter of HCFA's Center for Beneficiary Services at (410) 786-4636.

5. **Demonstrations:** For questions regarding policy and technical questions on the demonstration projects contact the assigned HCFA project officer.

This OPL was prepared by the Office of Clinical Standards and Quality in collaboration with the Center for Health Plans and Providers and the Center for Beneficiary Services.

Attachment I

HEDIS 2000 REQUIRED MEASURES FOR MEDICARE REPORTING FOR SUMMARY DATA

All HEDIS measures should be reported at the Contract/Market Area Level

Effectiveness of Care
Antidepressant Medication Management (for those with a drug benefit)
Cholesterol Management After Acute Cardiovascular Events

Breast Cancer Screening
Beta Blocker Treatment After A Heart Attack
Comprehensive Diabetes Care
Follow-up After Hospitalization for Mental Illness
Controlling High Blood Pressure
Medicare Health Outcomes Survey

Access to/Availability of Care
Adults' Access to Preventive/Ambulatory Health Services
Availability of Language Interpretation Services, Parts I & II

Health Plan Stability
Years in Business/Total Membership
Practitioner Turnover

Use of Services
Frequency of Selected Procedures
Inpatient Utilization - General Hospital/Acute Care
Ambulatory Care
Inpatient Utilization - Non-Acute Care
Mental Health Utilization - Inpatient Discharges and Average Length of Stay
Mental Health Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services
Chemical Dependency Utilization - Inpatient Discharges and Average Length of Stay
Chemical Dependency Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services
Outpatient Drug Utilization (for those with a drug benefit)

Health Plan Descriptive Information
Board Certification/Residency Completion
Total Enrollment by Percentage
Enrollment by Product Line (Member Years/Months)

REPORTING CLARIFICATIONS

The following HEDIS measures will **not** be required to be submitted for HEDIS 2000. HCFA receives this information through other data sources.

Health Plan Stability
Disenrollment
Indicators of Financial Stability

Cost of Care
High-Occurrence/High-Cost DRGs
Rate Trends

Health Plan Descriptive Information
Practitioner Compensation
Arrangements with Public Health, etc.

Attachment I.A

CONTINUING COST CONTRACTS: HEDIS 2000 REQUIRED MEASURES FOR MEDICARE REPORTING FOR SUMMARY DATA

All HEDIS measures should be reported at the Contract/Market Area Level

Effectiveness of Care

Antidepressant Medication Management (for those with a drug benefit)
Cholesterol Management After Acute Cardiovascular Events
Breast Cancer Screening
Beta Blocker Treatment After A Heart Attack
Comprehensive Diabetes Care
Follow-up After Hospitalization for Mental Illness
Controlling High Blood Pressure
Medicare Health Outcomes Survey

Access to/Availability of Care
Adults' Access to Preventive/Ambulatory Health Services
Availability of Language Interpretation Services, Parts I & II

Health Plan Stability
Years in Business/Total Membership
Practitioner Turnover

Use of Services
Ambulatory Care
Outpatient Drug Utilization (for those with a drug benefit)

Health Plan Descriptive Information
Board Certification/Residency Completion
Total Enrollment by Percentage
Enrollment by Product Line (Member Years/Months)

Attachment II

SUBMITTING PATIENT-LEVEL DATA

Required Measures

MCOs must provide the patient identifier, or HIC number, for all beneficiaries included in the summary data. MCOs must submit patient-level data by contract- market. The HIC number is assigned by HCFA to the beneficiary when s/he signs up for Medicare, and MCOs use this number for accretions and deletions. In addition to the patient identifier, MCOs also must provide the member month contribution for each beneficiary and indicate how each beneficiary contributed to the calculation of the following summary measures.

The list of required measures for 2000 is the same as 1999 with the addition of two new Effectiveness of Care measures (Controlling High Blood Pressure and Comprehensive Diabetes Care).

Note: Section 1876 cost contracts in 1999 (whether or not they convert to become an M+C MCO in 2000) should only report patient-level data for the summary measures that are listed in Attachment I.A.

Effectiveness of Care:

- Breast Cancer Screening
- Beta Blocker Treatment After A Heart Attack
- Comprehensive Diabetes Care
- Follow-up After Hospitalization for Mental Illness
- Antidepressant Medication Management
- Cholesterol Management After Acute Cardiovascular Events
- Controlling High Blood Pressure

Access/Availability of Care:

- Adults' Access to Preventive/Ambulatory Health Services

Use of Services:

- Frequency of Selected Procedures
- Inpatient Utilization - General Hospital/Acute Care
- Ambulatory Care
- Inpatient Utilization - Nonacute Care
- Mental Health Utilization- Inpatient Discharges and Average Length of Stay
- Mental Health Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services
- Chemical Dependency Utilization- Inpatient Discharges and Average Length of Stay
- Chemical Dependency Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services

To be useful, this patient-level data must match the summary data for the measures discussed here, *i.e.* the patient file should contain all beneficiaries enrolled in the contract at the time that the summary measures are calculated. To ensure an exact match, the MCO should make a copy, or Afreeze,@ its database when the summary measures are calculated. NCQA will provide MCOs with exact file specifications and explicit instructions by spring of 2000, which is sufficient time to allow MCOs to identify the best way to fulfill this requirement.

Attachment III

ADDITIONAL INFORMATION ON THE MEDICARE HEALTH OUTCOMES SURVEY

Data Feedback

Please remember that **individual patient-level data will not be provided to plans after baseline data collection**. However in 2000 you will receive the following from HCFA:

1999 HOS Plan Performance Profile - will be mailed to all plans participating in the 1999 HOS cohort two. This quality improvement tool, which presents an aggregate overview of the baseline health status of your MCO=s Medicare enrollees, was developed and extensively tested over the last year to ensure that MCOs would find the data useful and actionable. Accompanying the profile will be an information synthesis which provides insight into the types of interventions that show promise at improving functional status. Your state Peer Review Organization/Quality Improvement Organization will also receive copies of the performance profiles and stands ready to collaborate with you on interpreting the data, identifying opportunities to improve care, assisting you in planning effective, measurable interventions, and evaluating and monitoring the results of your interventions. Using data from the Health Outcomes Survey to plan and conduct a quality improvement project may fulfill one of the Quality Assessment and Performance Improvement requirements (QAPI) under QISMC. If you do not receive your performance profile by March 31, 2000 please contact Health Services Advisory Group (HSAG) at 1-(888) 880-0077 or e-mail to azpro.hos@sdps.org. Each MCO receives one performance profile free of charge. Additional and replacement copies are available **at cost** from HSAG.

1998-2000 Cohort One Patient Level Data - These data sets will be prepared and released to plans as soon as the follow up data are thoroughly analyzed. We anticipate availability in Spring 2001

Vendor Reports

The vendors administering the survey may provide you with reports on the progress of mail and telephone survey administration. Each report may consist of data on the number

of surveys issued during the first and second survey mailings, the number of surveys returned completed or partially completed, the number of sampled members for whom a survey could not be obtained (e.g., due to death, disenrollment, language barrier), and mail and telephone response rate calculations.

Please DO NOT ask your vendor for additional analyses or member specific data. They are prohibited from providing this type of information.

Requests for interpretation of the data or more detailed analyses of the data should be directed to your state PRO/QIO.

2001 Health Outcomes Survey Conference

The next Medicare Health Outcomes Survey conference may be held in Spring 2001. This conference will highlight results from cohort one, preliminary aggregate results from cohort two as well as reports on MCO/PRO collaborations on using Health Outcomes Survey data to improve the quality of care provided to Medicare beneficiaries. More information will be forthcoming.